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ABSTRACT

This speech highlights ethical considerations in defining "reasonable practice" or standards of care in cases of the recovery of sexual abuse memories. Knowing the ethical standards of the psychological profession is not sufficient. These standards cannot be and are not exhaustive in addressing all the ethical dilemmas that psychologists face. Reasoned judgment and evaluation must be used. General ethical principles are autonomy, fidelity, justice, beneficence, and nonmaleficence. Autonomy includes both freedom of action and freedom of choice. It is within this context that informed consent is important. Beneficence or "doing good" suggests that therapists have important positive obligations to clients in terms of contributing to their health and welfare. Several questions therapists should ask of themselves before proceeding with a sexually abused client are provided. Many ethicists believe the ethical principle of nonmaleficence, or "do no harm," is the primary ethical responsibility. Related to this principle is the issue of a priori assumptions that interfere with appropriate assessment and treatment. Specific questions that can be considered to evaluate the potential of harm to a client dealing with memories of sexual abuse are provided. Contains seven references. (JBJ)

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by Kathy Hotelling, Ph.D., ABPP

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ETHICAL ISSUES IN THE RECOVERY OF SEXUAL ABUSE MEMORIES

KATHY HOTELLING, PH.D., ABPP

One of the major concerns that has been raised as a result of the debate regarding the recovery of sexual abuse memories and the treatment of sexual abuse survivors has been legal liability. This concern has been picked up by the popular press and many practitioners have been threatened both explicitly and implicitly by this reality. As a result, in many instances ethical considerations have been overshadowed by our concerns about being sued. Certainly, the legal aspects of this type of work cannot be ignored. And although legal and ethical issues are often intertwined and discussed as one, ethical concerns regarding this highly volatile topic can be seen as separate and distinct. What I would like to do today is provide an ethical context for the treatment of this population.

Necessarily, there is overlap between the comments I will make and those of the other presenters. When there is not this overlap between our ethical responsibility and what thoughtful and trained clinicians are thinking and doing, problems arise. My task is to highlight the ethical considerations in defining "reasonable practice" or standards of care. Providing an underlying ethical framework for such standards is extremely important as we are called upon, perhaps in some cases forced to, evaluate our own and others' work in this area. For example, ethics committees are already dealing with consumers and professionals concerned about how practitioners are treating such clients and their alleged perpetrators.

Just knowing the ethical standards of our profession (APA, 1992) is not sufficient. These standards cannot be and are not exhaustive in terms of addressing all the ethical dilemmas that we will face during our careers. Therefore, we must use reasoned judgment and evaluation (Kitchener, 1984). In order to employ this level of thought, we must turn to the general ethical principles discussed by Beauchamp and Childress (1979) and applied to counseling psychology by Kitchener (1984).

Specifically these ethical principles are autonomy, fidelity, justice, beneficence, and nonmaleficence. Due to time limitations today, I would like to focus on the principles of autonomy, beneficence, and nonmaleficence.

Autonomy includes both freedom of action and freedom of choice (Kitchener, 1984) It is within this context that the concept of informed consent is important. More and more therapists are utilizing written disclosure statements at the beginning of therapy. Dauser, Hedstrom, and Croteau (1994) recommend that disclosure statements include an explanation of therapist training and experience, confidentiality, what to expect in therapy, the benefits and risks of therapy, among other items. This seems particularly important in working with those who identify themselves as sexual abuse victims. The disclosures need, however, to be reasonable in both length and type of content, unlike what the legislation pending in some states mandates. Discussing these topics will be part of the process of therapy as issues arise. As therapy progresses, legal and ethical options for clients need to be explained with choices

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regarding such actions, of course, remaining with the client.

The second ethical concept that I would like to discuss is beneficence or "doing good." This principle suggests that we have important positive obligations to our clients, specifically in terms of contributing to their health and welfare. It also implies the importance of providing competent service by being well versed in the research that underlies treatment options, maintaining and enhancing our expertise through continuing education and reading, and seeking consultation. Trust is a major issues for those who have been abused. Lack of skill, knowledge, and expertise betrays that individual's trust once again.

One's understanding and skill in the assessment and treatment of sexual abuse can be evaluated in part by considering the following:

> Before issues underlying behavioral problems are pursued, is ego strength evaluated?
>
> Is the client's susceptibility to suggestion appraised?
>
> Does the psychologist read books, view videotapes, etc. before recommending them?
>
> Does s/he caution clients who initiate utilizing such adjuncts to therapy on their own?
>
> Are appropriate cautions given regarding self help groups? Self help groups vary tremendously in their structure, "health," appropriateness for a given client at any given time, etc.
>
> Is supervision or consultation sought in cases of suspected abuse?

Many ethicists (Beauchamp & Childress, 1979)) believe that the ethical principle of nonmaleficence or "do no harm" is our primary ethical responsibility. This principle refers to not inflicting intentional harm and not proceeding in a manner that risks harming others.

Related to this principle is the issue of a priori assumptions that interfere with appropriate assessment and treatment. Very often childhood sexual abuse is not a presenting concern of clients. As Courtois (1988) has pointed out, the lack of recognition of sexual abuse or the failure to address the impact of early victimization can lead to treatment failure. This can be just as harmful as overzealousness in pursuing abuse histories. The American Psychiatric Association's Statement on Memories of Sexual Abuse (1993) reads: "Many individuals who have experienced sexual abuse have a history of not being believed by their parents, or others in whom they have put their trust. Expression of disbelief is likely to cause the patient further pain and decrease his/her willingness to seek needed psychiatric treatment. Similarly, clinicians should not exert pressure on patients to believe in events that may not have occurred, or to prematurely disrupt important relationships or make other important decisions based on these speculations." Furthermore, having inadequate training in psychology can make the use of specialized interview techniques especially dangerous, as evidenced in the case of the allegations against Cardinal Bernadin initially put forth by Stephen Cook.

There are some specific questions that can be considered to evaluate the potential of harm to a client when dealing with memories of sexual abuse:

> How is the topic of memories handled when the issue is raised by the client? Thoughtful, careful responses can leave the door open for either subsequent confirmation or disconfirmation of such past events:
>
> > "Memory is a tricky thing"
> >
> > "It is only a possibility, not a given, that sexual abuse occurred when we see these types of symptoms."
> >
> > "What's making you consider that?"
>
> Other questions include:
>
> > How was the process of retrieval initiated?
> >
> > What specific procedures (e.g., hypnosis) resulted in memories?
> >
> > What evidence is there? Is there corroboration, including in the case of hypnosis?

In addition to a priori assumptions, the issue of boundaries is very relevant to the ethical principle of doing no harm. As evidenced by the number of ethical standards related to multiple relationships and sexual intimacies in our present ethical code, boundary violations can be extremely injurious to those that we serve. Given the victimization and violations that have occurred in the past for this particular subset of clientele, psychologists need to be keenly aware of errors in this direction, including inappropriate self disclosure.

The potential impact of personal issues of the treating psychologist cannot be ignored when examining harm to clients. Given the significant number of clinical and counseling psychologists that report experiencing some form of physical or sexual abuse (Pope & Feldman-Summers, 1992), the monitoring of countertransference is extremely important and may require consultation for successful treatment and resolution. Given the emotional intensity of this therapeutic work, countertransference can also be related to the number of sexual abuse victims that a given practitioner treats. Self care must be initiated so that burn out and resultant poor judgment do not interfere with the client's therapy.

The treatment of sexual abuse victims is emotionally and ethically demanding, as is much of the therapeutic work that we do. Despite the controversies surrounding this topic, we must remain faithful to our ethical responsibilities. These clients, like any other, deserve high quality treatment and ethical behavior.

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